

## **RETURNTO:**

Delta Dental Plan of Colorado P.O. Box 173803 Denver, CO, 80217-3803

Customer Service:	1-800-4	189-7168														O 80217-3803
1. PATIENT NAME - PLEASE PRINT FIRST   LAST				2. RELATIONSHIP TO EMP SELF SPOUSE (				PLOYEE 3.SEX CHILD M F					THDATE YR	NATE   5. IF FULL TIME STUDENT, CITY YR SCHOOL NAME		NT, CITY, STATE,
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6. EMPLOYEE NAME										7. E	MPLC	YEES	SOCIAL S	ECURITY NUM	IBER 8	EMPLOYEE BIRTHDATE
FIRST			LAST	LAST								.	-	-		MO DAY YR
9. EMPLOYEE MAILING ADDRESS										10.1	NAME	OF E	MPLOYER	2		
											Sta	ate	of Co	olorado		
CITY			STATE			ZIP				11 (				select one onl	w)	
										''''		_	•			
42 IS DATIFAL COVEDED BY ANOTHER BLAND				ES, ATTACH EXPLANATION OF BENEFITS (EOB)					(EOP)	_	L	_ BA	SIC PI	an - 006784		
								SENEFITS (EOB)			☐ BASIC PLUS Plan - 006785					
NO SESSION NO 14. ENTER OTHER FAMILY MEMBER EMPLOYED WITH BENEFIT COVER											BIRTHDATE OTHER DENTAL PLAN NAME					
OTHER NAME		LATIONSHIP	FII COVERAGE.		C. SEC. N	Ο.				1	мо ¦	DAY		I	DENTALPL	AN NAME
<b></b>																
MY DENTIST MAY GIVE DELTA AND ANY OTHER C UNDERSTAND AND AGREE WITH THE TREATMEN															ENTAL WORK F	OR WHICH THIS CLAIM IS MADE. 1
15. SIGNATURE OF PATIENT																
(or parent or guardian)													DA	ATE		
16. DENTIST NAME						24. IS TREATM RESULT OF			LTOF		NO	YES	IF YES,	IF YES, ENTER BRIEF DESCRIPTION AND DATES.		
							OCCUPATIONAL ILLNESS OR INJU			AL JURY?	LUBY?			ļ		
17. MALING ADDRESS							25. IS TREATMENT RESULT OF					1.				
							RESULT OF AUTO ACCIDEN			NT?						
CITY			STATE		ZIP		26. OTHER A		RACCIE	CIDENT?						
18. DENTIST SOC. SEC. NO. OR TAX ID	NO 19	9. DENTIST LIC	SENSE NO 20	D. 20. DENTIST PHONE NO.			27. IF PROSTHESIS			S.			IF NO. RE	IF NO, REASON FOR REPLACEMENT?   DATE OF PRIOR		
IO. DENTION GOO. GEG. NO. ON TAXAB		STATE	/	١	01111011		27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			-			REPLACEMENT?			
21. PREDETERMINATION 22. PAR	N PAI	R 23 BADIC	OGRAPHS OR	NO	YES	HOW			ATMEN	T FOR			IF SERVIO	CES ALREADY CO	OMMENCED	MOS. TREATMENT REMAINING.
NO YES	IVI A		LSENCLOSED?			MANY?			ODONTI			$  \Box$	ENTER D	ATE APPLIANCE	S PLACED.	
		(4444) 4710) 4	110 705 1714511		<u> </u>		0)/075									
IDENTIFY MISSING TEETH WITH "X"	TOOTH		ND TREATMENT	IPLAN	I - USE CI	HARTING	SYSIE	M S	HOWN		DATE	SERV	/ICE		DENTIOT	
	OR	SURFACE	DE	SERVICE					DATE SERVICE PERFORMED			PROCEDURE NUMBER	DENTIST FEE	FOR DELTA USE ONLY		
FACIAL	QUAD	'	1								0   1	DAY	YR			
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FACIAL											<u> </u>					
30. REMARKS FOR UNUSUAL SERVICES											+		;			
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I HEREBY CERTIFY THAT THE PROCE									EES	1				TOTAL		
SUBMITTED ARE THE ACTUAL FEES I														TOTAL FEE		
31. DENTIST'S SIGNATURE							DATE							CHARGED		,
It is unlawful to knowingly provide	e false.	incomplete	<ul> <li>or misleadir</li> </ul>	na fac	ts to De	elta Der	ıtal Pla	an c	of Cold	rado t	o de	trauc	or atte	mpt to defr	aud Delta	Dental. Penalties may

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental Plan of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts to Delta participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

ATTENDING DENTIST'S STATEMENT		